BEFORE THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
JEFFERSON C. HENDRIX, M.D. Certificate #A-32571	)	File No: 04-92-17975
Respondent.	)	

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in the above-entitled matter.

This Decision shall become effective on May 23, 1996.

DATED April 23, 1996.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Ira Lubell, M.D.
Chair, Panel A

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 04-92-17975
JEFFERSON HENDRIX, M.D. 800 North Tustin, #M Santa Ana, CA 92705	OAH No. L-9410103
Physician's and Surgeon's No. A32571,	**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**
Respondent.	

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

1. An Accusation in Case Number 04-92-17975 was filed with the Medical Board of California, Department of Consumer Affairs (the "Board") on or about July 18, 1994, and is currently pending against Jefferson Hendrix, M.D. (the "respondent").

2. The Accusation, together with all statutorily required documents, was duly served on the respondent on or about July 18, 1994, and respondent has filed his Notice of Defense

contesting the Accusation. A copy of Accusation No. 04-92-17975 is attached as Exhibit "A" and hereby incorporated by reference as if fully set forth.

3. The Complainant, Ronald Joseph, is the Executive Director of the Medical Board of California and brought this action solely in his official capacity. The Complainant is represented by the Attorney General of California, Daniel E. Lungren, by and through Deputy Attorney General Samuel K. Hammond.

4. The respondent is represented in this matter by Peter R. Osinoff, Esq., whose address is 3699 Wilshire Blvd, Los Angeles, CA 90010.

5. The respondent and his attorney have fully discussed the charges contained in Accusation No. 04-92-17975, and the respondent has been fully advised regarding his legal rights and the effects of this stipulation.

6. At all times relevant herein, respondent has been licensed by the Medical Board of California under Physician's and Surgeon's No. A32571.

7. Respondent understands the nature of the charges alleged in the Accusation and that, if proven at hearing, the charges and allegations would constitute cause for imposing discipline upon Physician's and Surgeon's certificate. Respondent is fully aware of his right to a hearing on the charges contained in the Accusation, his right to confront and cross-examine witnesses against him, his right to the use of subpoenas to compel the attendance of witnesses and the

production of documents in both defense and mitigation of the charges, his right to reconsideration, appeal and any and all other rights accorded by the California Administrative Procedure Act and other applicable laws. Respondent knowingly, voluntarily and irrevocably waives and give up each of these rights.

8. Respondent admits only that he failed to document the patients' medical records to indicate the medical histories of the patients, physical examinations performed, the treatments rendered, and the medications prescribed as described in paragraphs 9 through 12 in Accusation No. 04-9217975. Respondent agrees that by this failure, he has subjected his physician's and surgeon's certificate to disciplinary action. Respondent agrees to be bound by the Board's Disciplinary Order as set forth below.

9. The admissions made by respondent herein are for the purpose of this proceeding and any other proceedings in which the Medical Board of California, or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceedings.

10. Based on the foregoing admissions and stipulated matters, the parties agree that the Board shall, without further notice or formal proceeding, issue and enter the following order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's number A32571 issued to Jefferson Hendrix, M.D. is revoked. However, the revocation is stayed and respondent is placed on probation for five (5) years on the following terms and

conditions. Within 15 days after the effective date of this decision, the respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. **ORAL CLINICAL OR WRITTEN EXAM**

Respondent shall take and pass an oral clinical exam in subjects involving General Practice, Pharmacology and Attention Deficit Disorder administered by the Division, or its designee. This examination shall be taken within ninety (90) days after the effective date of this decision. If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of a written as well as an oral examination. The waiting period between the first and second examinations shall be at least three (3) months. If respondent fails to pass the first and second examination, respondent may take a third and final examination after waiting a period of one (1) year. Failure to pass the oral clinical examination within eighteen (18) months after the effective date of this decision shall constitute a violation of probation. The respondent shall pay the costs of these examinations within ninety (90) days of the administration of each exam. Failure to pay these costs shall constitute a violation of probation.

If respondent fails the first examination, respondent shall be suspended from the practice of medicine until a repeat examination has been successfully passed, as evidenced by written notice to respondent from the Division or its designee.

2. **EDUCATION COURSE**

Within ninety (90) days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval an educational program in the areas of general practice, pharmacology and Attention Deficit Disorder which shall not be less than 40 hours per year, for each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure.

3. **ETHICS COURSE**

Within sixty (60) days of the effective date of this decision, respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

4. **MONITORING**

Within thirty (30) days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, who shall provide periodic reports to the Division or its designee.

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If the monitor resigns or is no longer available, respondent shall, within fifteen (15) days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

5. **PRESCRIBING PRACTICES COURSE**

Within sixty (60) days of the effective date of this decision, respondent shall enroll in a course in Prescribing Practices, approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

6. **CONTROLLED DRUGS - MAINTAIN RECORD**

Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by respondent during probation, showing all the following: 1) the name and address of the patient, 2) the date, 3) the character and quantity of controlled substances involved, and 4) the indications and diagnoses for which the controlled substance was furnished.

Respondent shall keep these records in a separate file or ledger, or on duplicate prescription pads in chronological order, and shall make them available for inspection and copying by the Division or its designee, upon request.

7. **NO DISPENSING OF CONTROLLED SUBSTANCES AND DANGEROUS DRUGS IN OFFICE PRACTICE**

Respondent shall not dispense any controlled substances or dangerous drugs as defined in Business and Professions Code section 4211, from his office practice. All medication

prescribed by respondent shall be on written prescriptions to be filled at a pharmacy.

8. **NO PRESCRIBING OR DISPENSING FOR SELF, FAMILY OR EMPLOYEES**

Respondent shall not dispense or prescribe any controlled substances or dangerous drugs as defined in Code section 4211 for himself, his employees or any employee of a practice with which he is affiliated, nor for his family members.

9. **OBEY ALL LAWS**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

10. **QUARTERLY REPORTS**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

11. **PROBATION SURVEILLANCE PROGRAM COMPLIANCE**

Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

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Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

12. **INTERVIEW WITH THE DIVISION, ITS DESIGNEE OR ITS DESIGNATED PHYSICIAN(S)**

Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

13. **TOLLING FOR OUT-OF-STATE PRACTICE, RESIDENCE OR IN-STATE NON-PRACTICE**

In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten (10) days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

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Any respondent disciplined under Business and Professions Code section 2305 (sister-state discipline) may petition for modification of penalty; 1) if the other state's discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.

14. **COMPLETION OF PROBATION**

Upon successful completion of probation, respondent's certificate shall be fully restored.

15. **VIOLATION OF PROBATION**

If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. **COST RECOVERY**

The respondent is hereby ordered to reimburse the Division the amount of $5,000 for its investigative and prosecution costs to be paid as follows: Within 90 days of the effective date of the decision, respondent shall make the first (1st) installment payment of $2,000. Respondent shall make the second (2nd) installment payment of $1,000 within two (2) years of the effective date of the decision. Respondent shall make the third (3rd) installment payment of $1,000 within three (3) years

of the effective date of this decision. Respondent shall make the last installment payment of $1,000 within four (4) years of the effective date of this decision. Failure to reimburse the Division's cost of investigation and prosecution in accordance with the installment plan above, shall constitute a violation of the probation order, unless the Division agrees in writing to an amendment to the installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

17. **PROBATION COSTS**

Respondent shall pay $1,000 as costs associated with probation monitoring each and every year of probation. Such costs shall be payable to the Division of Medical Quality and delivered to the designated probation surveillance monitor at the beginning of each calendar year. Respondent's failure to pay costs within 30 days of the due date shall constitute a violation of probation.

18. **LICENSE SURRENDER**

Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance

of the tendered license, respondent will not longer be subject to the terms and conditions of probation.

CONTINGENCY

This stipulation shall be subject to the approval of the Board. Respondent understands and agrees that Board staff and counsel for complainant may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by respondent or counsel. If the Board fails to adopt this stipulation as its Order, the stipulation shall be of no force or effect, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action in this matter by virtue of its consideration of this stipulation.

ACCEPTANCE

I have read the above Stipulated Settlement and Disciplinary Order. I have fully discussed the terms and conditions and other matters contained therein with my attorney, Peter R. Osinoff, Esq. I understand the effect this Stipulated Settlement and Disciplinary Order will have on my Physician's and Surgeon's, and agree to be bound thereby. I enter this stipulation freely, knowingly, intelligently and voluntarily.

DATED: 3/4/96

JEFFERSON HENDRIX, M.D.
Respondent

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I have read the above Stipulated Settlement and Disciplinary Order and approve of it as to form and content. I have fully discussed the terms and conditions and other matters therein with respondent Jefferson Hendrix, M.D..

DATED: 3/6/96.

Peter R. Osinoff
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for the consideration of the Medical Board of California, Department of Consumer Affairs.

DATED: 3/14/96.

DANIEL E. LUNGREN, Attorney General
of the State of California

SAMUEL K. HAMMOND
Deputy Attorney General

Attorneys for Complainant

ACCUSATION

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Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JEFFERSON C. HENDRIX, M.D. 800 North Tustin, #M Santa Ana, California 92705 California Physician's and Surgeon's Certificate No. A32571 Respondent.	Case No. 04-92-17975 ACCUSATION

COMES NOW Complainant Dixon Arnett, who as cause for disciplinary action against the above-named and -encaptioned Respondent, charges and alleges as follows:

1. Complainant is the Executive Director of the Medical Board of California, Department of Consumer Affairs, State of California (hereinafter the "Board"), and makes and files this Accusation solely in his official capacity as such and not otherwise.

2. License Status. On or about July 1, 1978, Jefferson C. Hendrix, M.D., Respondent herein and hereinafter referred to as "Respondent", was issued Physician's and Surgeon's Certificate No. A 32571 by the Board authorizing him to practice medicine in the State of California. At all times herein relevant said Certificate was, and now is, in full force and effect. Respondent is not authorized to supervise Physician Assistants.

3. Jurisdiction. Section 2220 of California's Business and Professions Code [hereinafter, "the Code"] provides that the Division of Medical Quality may take action against a physician who has been guilty of violating any of the provisions of the Medical Practice Act, i.e., Chapter 5 of Division 2 of the Code. Section 2227 of the Code provides that a physician whose matter has been heard by the Division of Medical Quality, by a medical quality review committee or a panel of such committee, or by an administrative law judge, or whose default has been entered, and who is found guilty: (a) may have his or her certificate revoked; (b) may have his or her right to practice suspended for a period not to exceed one year; (c) may be placed on probation; (d) may be publicly reprimanded; and/or (e) may have such other action taken in relation to discipline as is deemed proper in the matter.

4. Summary of Allegations. This Accusation is brought charging Respondent with being subject to disciplinary action for unprofessional conduct pursuant to the following sections of the Medical Practice Act: § 2234 [Unprofessional Conduct] per §§

2234(b) [Gross Negligence], 2234(c) [Repeated Negligent Acts], and 2234(d) [Incompetence]; and §§ 2238 [Violation of Drug Statutes], and 2242 [Furnishing Dangerous Drugs Without A Good Faith Prior Examination or Medical Indication]; as well as § 725 of the Business and Professions Code [Excessive Prescribing].

In addition, Complainant will seek reimbursement from Respondent for the Board's reasonable costs of investigation and enforcement of this matter, pursuant to section 125.3 of the Code.[1/]

CHARGES & ALLEGATIONS

Statutes

A.

[Gross Negligence, Repeated Negligent Acts, and Incompetence]

5. Section 2234 of the Medical Practice Act provides that the Board shall take action against any physician who is guilty of unprofessional conduct. Subdivision (b) of the section provides that the unprofessional conduct for which a physician may be disciplined includes gross negligence; subdivision (c) of the section provides that it includes the commission of repeated negligent acts; and subdivision (d) provides that it also includes incompetence.

6. Respondent is subject to disciplinary action pursuant to section 2234 because he has committed acts of unprofessional conduct within the defined meanings of subdivisions (b)-[gross negligence], (c)-[repeated negligent

[1]Section 125.3 of the Code provides that in any Order issued in resolution of a disciplinary proceeding, a Board may request the Administrative Law Judge to direct a licentiate found to have committed a violation or violation of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, incurred up to the date of the hearing, including charges imposed by the Attorney General.

acts], and (d)-[incompetence] of that section, in the course of his care, management, and treatment of the four patients named herein, to wit, R.S., J.Z., J.M., and M.S. Particularly and without limitation, the detailed allegations which follow at paragraphs 9&9A, 10&10A, 11&11A, and 12&12A show that in the course of their care (a) he demonstrated gross negligence by departing in the extreme from the standards of the medical community or (b) he repeatedly committed negligent acts by repeatedly departing from the community standard of care, and (c) he demonstrated incompetence by showing a lack of knowledge of medical matters and/or an inability to properly discharge his professional obligations.

B.

[Prescribing Without A Good Faith Medical Examination, Excessive Prescribing, Violation of Drug Statutes]

7. In addition to the aforementioned grounds for discipline,

--subdivision (a) of section 2242 of the Medical Practice Act provides that prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4211[2/] without a good faith prior examination and medical indication also constitutes unprofessional conduct for which a physician may be disciplined;

--section 2238 of the Medical Practice Act provides that a violation of any federal or state statute or regulation regulating dangerous drugs or controlled substances constitutes

[2]A "dangerous drug" as defined by section 4211 of the Business and Professions Code is one which requires a prescription in order to be dispensed. Specifically, the section defines "dangerous drug", inter alia, as "any drug unsafe for self-medication ... and includes ... (a) [a]ny drug which bears the legend: `Caution: federal law prohibits dispensing without prescription' or words of similar import...."

unprofessional conduct for a physician as well; and

--section 725 of the Code provides that repeated acts of clearly excessive prescribing of drugs[3/] as determined by the standard of the community of licensees, also constitutes unprofessional conduct for which a physician may be disciplined.

8. Respondent is also subject to disciplinary action for unprofessional conduct pursuant to sections 2242(a) and 2238 of the MPA and section 725 of the Code because the matters set forth hereinbelow in paragraphs 9&9B, 10&10B, 11&11B, and 12&12B also show that in the course of his care, treatment, and case management of the patients named therein —again, R.S, J.Z., J.M., and M.S., Respondent either (i) prescribed, furnished, or dispensed dangerous drugs to and for them without having made a good faith prior examination in violation of section 2242(a), and/or (ii) repeatedly clearly excessively prescribed drugs for them[4/] in violation of section 725, and/or (iii) violated several state and federal statutes and regulations regulating dangerous drugs and controlled substances in violation of section 2238 —to wit, section 11153 and/or section 11154 and/or section 11210 of California's Health and Safety Code, which require, respectively, that prescriptions for controlled substances be issued for legitimate medical purposes, that they only be issued to treat a

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[3] Section 2051 of the Medical Practice Act provides that a physician's and surgeon's certificate authorizes the holder to use "drugs" in or upon human beings in the treatment of diseases, injuries, deformities, and other physical and mental conditions. For purposes of the Act, the term "drugs" is understood to mean substances (or articles) recognized in the official United States Pharmacopoeia, official U.S. Homeopathic Pharmacopoeia or the official National Formulary, or substances intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease. (Cf. 64 Ops.Cal.Atty.Gen. 240, 242 fn.5 (1981); Bus. & Prof. Code, § 4031; Health & Saf. Code, § 11014; Pen. Code, § 383, Veh. Code, § 312.)

[4] Since the term "prescribe" means the selection of a particular drug (its identity and dosage) for a patient's use, and the issuance of an order for it to be supplied to the patient as by a pharmacist (cf. Bus. & Prof. Code, § 4036, subd. (a); Health & Saf. Code, § 11027), it embraces both the initial order as well as subsequent refills.

pathology or condition, and that the medications only be prescribed in such quantity and for such period of time as is reasonably necessary[5/].

Factual Predicates & Particular Allegations

9. Patient R.S. Ms. R.S. was a 46 year old female with a complicated medical history which included a history of psychiatric disease (including multiple personality disorder and panic attacks for which she had been followed), a history of benign uterine and ovarian tumors, multiple D&C's and a hysterectomy in 1985, a 20+ year history of hypertension (felt secondary to idiopathic hyperaldosteronism and perhaps related to bilateral cortical nodular hyperplasia), a left adrenalectomy in 1987 and postoperative medical therapy with cytadren, and a past history of hyperlipidemia.

She first saw Respondent on October 23, 1990, when she was admitted to the St. Joseph Hospital in Orange following a polydrug overdose. The past medical history was limited to the notation "see previous admissions" and a limited physical examination was performed. R.S. was treated with supportive therapy and subsequently discharged later the same day. Thereafter she saw Respondent at his office from March 1991 through June 1993, for an assortment of medical problems, including hypertension, foot infections, as well as major

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[5]Section 11007 of the Health and Safety Code defines a "controlled substance" as "a drug ... which is listed in [one of the five Schedules (of controlled substances) set forth by sections 11054 (Schedule I) through 11058 (Schedule V) of the Health and Safety Code]." Section 11153 of the Health and Safety Code provides, inter alia, that a prescription for a controlled substance shall only be issued for a legitimate medical purpose. Section 11154 of the Health and Safety Code, a statute regulating controlled substances, provides that no person shall knowingly prescribe or furnish a controlled substance to or for any person who is not under his or her treatment for a pathology or condition. Section 11210 provides that a physician shall prescribe controlled substances only in such quantity and for such length of time as is reasonably necessary.

In addition, it is also noted that section 11157 of that Code provides that no person shall issue a prescription that is false or fictitious in any respect.

psychiatric illness, thus:

1991

--R.S. was seen by Respondent in his office on March 7, 1991. Neither an interval history nor a past medical history was recorded and the physical examination was limited to a blood pressure recording of 180/?.[6] Respondent's clinical impression was hypertension and Respondent increased the dose of Procardia[7] R.S. was taking to 60 mg.

--R.S. returned for a blood pressure check on March 8th and a blood pressure of 170/110 was recorded.

--On March 11th, she returned complaining of a sinus headache of two weeks's duration. Respondent's physical examination was limited to taking and recording her blood pressure (184/120) and finding tenderness over the left maxillary area. The impression was "sinus" and "hypertension." Respondent prescribed Septra-DS at an unknown dosage. R.S.'s anti-hypertensive treatment regimen was not listed nor was her poorly-controlled hypertension addressed.

--On March 14th, R.S. returned for another blood pressure check and a reading of 184/104 was recorded.

[The next four entries in the office record were notations refilling prescription medications that included Procardia, Midamor[8], Tagamet[9] and Lopid[10].]

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[6]Blood tests drawn in January and February of 1991 included a CBC (notable for a hemoglobin of 11.4), an elevated ESR of 71mm/hr, and a SMA that revealed a serum cholesterol of 228, triglycerides of 267, a glucose of 107, and a creatinine of 0.7.

[7]Procardia (nifedipine) is an anti-anginal drug.

[8]Midamor (amiloride) is a kaliuretic-diuretic used in congestive heart failure and hypertension.

[9]Tagamet (cimetidine) is used in the short term treatment of duodenal ulcer.

--On April 25th, R.S. returned, complaining of fatigue, cramping in the lower extremity, and worsening tremors. She reported that she had stopped taking her Procardia. Respondent's examination was limited to obtaining a blood pressure reading of 168/98. The sole recorded impression was "tremor". Cogentin 1mg BID was prescribed[11] and laboratory tests (CBC, 5'HIAA) ordered.

--On May 2nd, R.S. returned, complaining of thirst, fatigue, headache, nausea, vomiting, palpitations, and an inability to focus her eyes and thoughts. Respondent's examination of her was once again limited to taking her blood pressure (a reading of 168/98 was obtained). The Cogentin was discontinued and an EKG and blood tests were ordered (which reported normal serum electrolytes, calcium and magnesium, a CBC revealing a mild anemia with hematocrit of 32.4, and a SMA with a normal glucose and elevated lipids).

--On May 6th, R.S. returned to the office reporting that she had experienced a seizure since her last visit and had undergone evaluation in an emergency room with a CT scan (a negative non-contrast CT scan per a radiology report). No examination was recorded. She was prescribed Phenobarbital[12] at an unrecorded dose. An EEG (which turned out negative) was ordered.

--R.S. was next seen on May 28th with complaints of fatigue and a "low blood test." Respondent's examination was

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[10] Lopid (gemfibrozil) is a lipid regulating agent used in reducing risk of coronary heart disease & very high elevations of serum triglycerides.

[11] Cogentin (benztropine mesylate) is used in treatment of Parkinsonism; it has atropine-like side- effects.

[12] Phenobarbital is a Schedule IV Barbiturate.

limited to taking and recording a blood pressure of 180/94.[13] The record did not indicate the medications R.S. was then taking.

--On June 6, R.S. was instructed to increase her Imipramine dose to 250mg a day[14] and to reduce her Premarin dose to 0.625mg every other day. An interval history was not obtained and there was no psychiatric history or mental status examination recorded in the medical record.

[The next two entries were medical refills of Tagamet, Midamor, Cortaf, Cytadren[15] and Tofranil[16].]

--On July 19th, R.S. returned to the office with the complaint of left knee pain for the past week as well as a three day history of palpitations and fatigue. Respondent's physical examination was once again limited to taking and recording a blood pressure (166/100). No assessment or treatment plan was recorded. A blood pressure check on July 23rd revealed a reading of 168/92.[17]

--On July 20th, R.S. returned complaining of continued pain in the left knee. Respondent's examination was limited to taking and recording a blood pressure (of 158/102). He prescribed Tolectin-DS QID[18] and a brace, and referred R.S. for

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[13] Laboratory tests were ordered -e.g., SMA, CBC, thyroid, ESR, cortisol, estrogen, and imipramine levels. Blood test results included a ESR of 70mm/hr, a glucose of 173, and a mild anemia with a hematocrit of 30.2.

[14] Imipramine (Tofranil) is an antidepressant.

[15] Cytadren (aminoglutethimide) is used in the suppression of adrenal function in patients with Cushing's syndrome (hyperadrenalism).

[16] Tofranil is an antidepressant.

[17] In addition, an ESR obtained that day was 110 mm/hr; a SMA revealed a glucose of 168 and an elevated cholesterol and triglycerides and a mild anemia. A knee x-ray was negative.

[18] Tolectin-DS (Tolmetin sodium) is used to treat rheumatoid arthritis, osteoarthritis, etc.

orthopedic consultation.

--On August 19th, R.S. returned complaining of a painful fissure under the right great toe. Respondent's examination was limited to taking and recording a blood pressure reading of 140/110. He prescribed Septra-DS[19] at an unstated dose. No notation as to her poorly controlled hypertension was recorded.

[Medications were refilled August 26th.]

--A blood pressure check on September 17th revealed a blood pressure of 140/90.

--On September 24th, R.S. returned with complaints of weakness, insomnia, vomiting, dizziness, and cramping in the extremities and back for 6 days. Respondent's documented examination was limited to recording a temperature of 98.8° and a blood pressure of 132/88. No assessment or treatment plan was recorded.[20]

--On September 30th, Zyloprim[21] was prescribed for unstated reasons.

--On October 23, R.S. returned to the office. The entry revealed only that the blood pressure was 174/114. "Meds" were increased to 3 twice a day. A blood pressure check on October 28th listed a reading of 128/80. Cultures were sent from the right great toe.

--R.S. was seen in follow-up on October 31th. Cultures

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[19] Septra-DS (trimethoprim & sulfamethoxazole) is a synthetic anti-bacterial used to treat urinary tract infections.

[20] Laboratory sent September 25th was notable for a uric acid of 10.9, a glucose of 131, and a low TSH value of 0.1.

[21] Zyloprim (allopurinol) reduces serum and urinary uric acid; it is used in treatment of gout, etc.

from the toe revealed heavy growths of pseudomonas aeruginosa, staphylococcus aureus, and Group B streptococcus. Respondent's examination was limited to taking and recording a blood pressure recording of 140/94 and the observation "feel a pulse." He referred R.S. for surgical consultation and prescribed Erythromycin 250[22] and Cipro 500[23] at unstated dosages.

--R.S. returned to the office November 8th and Respondent noted "multiple personalities". However, neither a psychiatric history nor a mental status examination was recorded. She was prescribed Thorazine and referred to a Dr.W.

--On November 11th, R.S. returned to the office complaining that her toe was beginning to smell again. Respondent's examination was limited to taking and recording a blood pressure of 168/102. Cipro and EES[24] were prescribed at unrecorded dosages.

--R.S. returned on December 16th with complaints of foot swelling, with numbness/aches of the 1st toe, weakness of the left foot, and an inability to feel a tack in the foot. Respondent's examination was limited to taking and recording a blood pressure reading (of 160/92) and the finding of a reduced sensation to pinprick in the feet bilaterally. A lumbar/sacral spine series was ordered as well as laboratory tests (CBC, SMA,

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[22] Erythromycin is an antibiotic.

[23] Cipro (ciprofloxicin) is a synthetic broad-spectrum antibacterial, used to treat lower respiratory infections, skin infections, bone & joint infections and urinary tract infections.

[24] EES (erythromycin ethylsuccinate) is an antibiotic.

B-12, and folate)[25]; consideration was also given towards ordering a nerve conduction study.

1992

The first entry in 1992 was recorded on February 17th, with R.S. complaining of pain at the tip of the right toe for the past 5 days. Respondent's examination was limited to taking and recording a blood pressure of 170/114 and finding erythema, edema and hyperkeratosis of the toe.[26] His impression was to rule out osteomyelitis. Cipro was prescribed at an unrecorded dose and a CBC and x-ray (which turned out negative) ordered.

--R.S. next returned February 21st complaining of continued pain in the toe. Respondent's documented examination was limited to taking and recording a blood pressure reading of 150/110. A bone scan was ordered and consultation with surgery and podiatry ordered. An ESR obtained February 24 was elevated at 60 mm/hr and a mild anemia was found on CBC with a hemoglobin of 9.7. A bone scan performed March 2 was negative for osteomyelitis.

--On March 11th, R.S. called with the complaint of vaginal discomfort. She was advised to try Betadine[27] and, if that did not work, Flagyl at a dose of 500mg BID[28].

--R.S. returned to the office on March 20th (?) for a

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[25] Notable results of the laboratory tests ordered included the finding of a mild anemia with a hematocrit of 31.6, a glucose of 145, and an elevated cholesterol (232) and triglyceride (629).

[26] Erythema is the abnormal flushing of the skin caused by dilation of the blood capillaries. (Gr. erythrós =red.) Edema is an excessive accumulation of fluid resulting in swelling. Hyperkeratosis is the thickening of the outer horny layer of the skin.

[27] Betadine (povidone-iodine) is a topical antiseptic.

[28] Flagyl (metronidazole hydrochloride) is a synthetic antibacterial for infections, anaerobic bacteria.

blood pressure check. Respondent's examination of her was limited to taking and recording a blood pressure reading of 198/124. She was advised to begin Catapres at a dose of 0.1mg BID[29] and to continue her Midamor at an unstated dose and Vasotec 10mg BID[30]. R.S. reportedly refused to take Procardia.

--On March 24th, R.S. was seen and indicated that she had awakened with a severe left-sided head pain; she also stated that she did not take the Catapres as recommended. The blood pressure was determined to be 184/128 at 10:20AM, fell to 170/122 by 11AM after a dose of sublingual Procardia. A limited examination revealed benign fundi, a supple neck, spasm and tenderness in the area of the trapezius and TMJ, and an "intact" neuro examination. The impression was "tension headache" due to PTSD (? post-traumatic stress disorder). Respondent's recorded treatment plan is illegible.

--R.S. returned the next day, March 25th, complaining of continued headache. Respondent's examination was limited to an initial blood pressure reading of 168/122 that fell to 156/122 at 10:30AM following a 10mg sublingual dose of Procardia, a reading of 200/138 at 11AM that prompted a second dose of sublingual Procardia. No other assessment was recorded nor was a treatment plan written.

[R.S. was subsequently hospitalized and admitted to an ICU at Western Medical Center in Santa Ana, CA where her blood pressure was controlled with the use of Catapres 0.2mg BID and

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[29] Catapres (clonidine hydrochloride) is an anti-hypertensive.

[30] Vasotec (enalapril maleate) is an anti-hypertensive.

Trandate 200mg BID and sublingual Procardia on a prn basis. Discharge medications were Vasotec 20mg daily, Midamor 10mg daily, Catapres 0.2mg BID, Trandate 200mg BID[31], Synthroid 0.2mg daily[32], Thorazine 25mg qhs[33], Xanax .05mg qhs, Imipramine 100mg in AM and 150mg in PM, Cortef 10mg daily, and Lopid 600mg BID. The admission H & P was performed by Respondent and dictated on May 23rd]

--R.S. returned to Respondent's office on March 30th. A blood pressure check revealed a pressure of 130/84 and the Catapres was reduced to 0.1mg per day. Blood pressure checks were made on April 2nd, April 15th, and June 12th and revealed pressures of 122/80, 142/92 and 130/92 respectively.

--In an office visit on June 26th, R.S. reported a two week history of a sore throat, a low grade fever, and numbness of the right foot, with worsening tremors and fatigue. She was found to be afebrile (no fever), with a blood pressure of 100/80, and had normal DTR's and motor function, but reduced pinprick sensation in a stocking distribution of an unstated lower extremity. A lumbar/sacral spine x-ray (which revealed degenerative spondylosis and discogenic disease) was ordered and serum B-12 (found to be low normal at 280) and folate (found to be normal at 3.0) levels ordered. An ESR sent June 29th was elevated at 70 mm/hr and the serum glucose was 139.

--On July 14th, R.S. was treated with Septra-DS for an

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[31] Trandate (labetalol hydrochloride) is an anti-hypertensive.

[32] Synthroid (levothyroxin) is used to treat hypothyroidism.

[33] Thorazine (chlorpromazine) is used for psychotic disorders.

early otitis media[34]. A CT scan of the L/S spine was ordered; as reported it revealed only neural foraminal narrowing at L3-4, L4-5, and L5-S1.

--On July 27th, R.S. was treated for "arthritis" and "radiculitis"[35] with Motrin and Ceclor.[36]

--R.S. returned August 20th complaining of fatigue, cough, dizziness and GI upset. Respondent's examination was limited to taking a blood pressure (?/110). He prescribed Tessalon and PCE.[37]

[The remaining entries in 1992 in Respondent's record were notations of refills of R.S.'s medications which included Tofranil, Trandate and Cortef.]

1993

--On February 9th, R.S. complained of fatigue and worsening of her hand and body tremors. Respondent's examination was limited to taking and recording a blood pressure reading of 150/102. A radiculopathy was suspected and a nerve conduction study ordered, which revealed findings consistent with tarsal tunnel syndrome vs. posterior tibial neuropathy.[38] The visit was also for medical clearance for foot surgery.

--On February 16th, R.S. returned to the office. A blood pressure of 150/92 was recorded. She was told to continue

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[34] Otitis media is an inflammation of the inner ear due to bacterial or viral infection. Unless treated, it can lead to conductive deafness.

[35] Radiculitis is the inflammation of the root of a nerve.

[36] Motrin is an anti-inflammatory. Ceclor (cefaclor) is a semisynthetic antibiotic.

[37] Tessalon (benzonatate) is a non-narcotic oral anti-tussive. PCE, an anti-bacterial, is erythromycin particles in tablets.

[38] Because of the abnormal nerve conduction study, R.S. was subsequently (March 4th) referred to a Dr. L.

Catapres TTS; a "H&P - foot surgery" was referred to.

--She returned February 26th complaining of pain in the right groin radiating down the leg. Respondent's impression is illegible. He prescribed Motrin at an unrecorded dose.

--On March 4th, Respondent administered Lasix at a dose of 40 mg IV. No interval history was obtained and his examination was limited to taking and recording a blood pressure determination of 158/114.

--R.S. returned to Respondent on March 18th complaining of intermittent fevers and weakness and shakiness for the past month. No examination other than a temperature of 98.8 degrees and a blood pressure of 122/78 was recorded. Anemia was considered the likely diagnosis and a CBC, SMA, and an ANA (which proved negative) was ordered. Fergon BID was advised on March 26th.

--On April 1st, R.S. complained of insomnia as well as low back pain and reported an emergency room visit for a fall. Examination revealed a blood pressure of 150/88 and an equivocal straight leg-raising test. A radiculopathy was diagnosed and R.S. prescribed Voltaren at an unrecorded dosage.[39]/

--On April 30th, R.S. returned to Respondent for follow-up. She noted continued fatigue and postural symptoms with near syncope. Her blood pressure was found to be 160/90 but orthostatic changes were not assessed. No other examination was performed. The impression was anemia and R.S. was advised to hold the Catapres. An EGD and ? colonoscopy were recommended.

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[39]Voltaren (dicophenac sodium) is an anti-inflammatory.

--A blood pressure check on May 4th revealed a blood pressure of 130/100.

[An appointment with Dr. D.H. (Internal Medicine-Gastroenterology was referred to in an entry dated May 10th, and Respondent notes the consult in the record of May 17th.]

--On May 17th, R.S. complained of fatigue but less dizziness. Respondent's examination of her was limited to securing a blood pressure reading of 180/110. He advised her to restart the Clonidine.[40/]

[Blood tests obtained on May 20th included a CBC which revealed a hemoglobin of 10.0, a B-12 level less than 100, and a Fe/TIBC of 45/312 with only 14% saturation.]

--On June 10, a blood pressure of 120/86 and a hemoglobin of 9.9 and a hematocrit of 30.5 was noted. No intervening history was obtained and no other examination was recorded. Respondent's impression was B-12 deficiency and tarsal tunnel syndrome. A hematology consultation was advised and scheduled with Dr. P. on June 15th.

--R.S. returned on June 14th following a bite on her left hand by a friend's cat the day before and was given samples of Cipro. Tetanus toxoid was administered.

--And lastly, on June 30th R.S. returned reporting fevers for 3 days as well as pain in the left groin and left foot accompanied by swelling on the underside of the left toe. She also reported reduced sensation up to the midcalf for the past three days as well as expressible pus from the left toe. No

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[40] Clonidine (catapres) is an anti-hypertensive.

examination was recorded other than a blood pressure of 150/100. No assessment or treatment plan was present in the medical record.

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A. Gross Negligence, Repeated Negligent Acts, & Incompetence. Respondent is subject to disciplinary action pursuant to section 2234 because in the course of his care, treatment, and case management of R.S. he demonstrated unprofessional conduct within the meanings of subdivisions (b)-[gross negligence] and/or (c)-[repeated negligence], and (d)-[incompetence], of that section. Particularly and without limitation, the following aspects of Respondent's care, treatment, and case management indicates, (i) he was guilty of gross negligence by departing in the extreme from the standards of the medical community, or was guilty of repeatedly committing negligent acts by repeatedly departing from the medical community's standards, and (ii) that he demonstrated incompetence by displaying a lack of knowledge of medical matters and/or an inability to discharge his professional obligations:

a. *Throughout The Time He Saw R.S., Respondent Failed To Record A Complete History and Physical Examination or Provide Appropriate Follow-up Care On A Patient Who Was Being Managed Longitudinally For Various Medical Conditions (i.e., Hypertension, Foot Infection) As Well As Major Psychiatric Illness.* Particularly,

i. *Respondent Failed To Provide Appropriate Medical Care For A Patient Being Managed For Chronic*

Hypertension. The standard of care posits that patients diagnosed with hypertension should have a complete medical history taken[41], a comprehensive initial physical examination[42], and initial laboratory screening[43]. Thereafter, regular follow-up visits (which should include an interval history, pertinent examination including but not limited to the determination of blood pressure, and appropriate laboratory tests) are required for all patients being managed for hypertension and are performed at intervals guided by clinical judgment, patient adherence to therapy, adequacy of blood pressure control, and associated medical and abnormal laboratory results. Elevated blood pressures found on follow-up visits should be clinically addressed and a management plan formulated for the attainment of the goal blood pressure.[44]

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[41]The medical history should include the following: (1) family history of high blood pressure and cardiovascular disease; (2) patient history of cardiovascular, cerebrovascular, and renal disease, as well as diabetes mellitus; (3) known duration and levels of elevated blood pressure; (4) results and side effects of previous antihypertensive therapy; (5) history of weight gain, exercise activities, sodium and fat intake, and alcohol use; (6) symptoms suggesting secondary hypertension; (7) psychosocial and environmental factors that may influence blood pressure control; and (8) other cardiovascular risk factors (including obesity, smoking, hyperlipidemia, and carbohydrate intolerance.

[42]The initial physical examination should include the following: (1) two or more blood pressure measurements with the patient either supine or seated and standing; (2) verification in the contralateral arm; (3) measurement of height and weight; (4) funduscopic examination for arteriolar narrowing, arteriovenous compression, hemorrhages, exudates, and papilledema; (5) examination of the neck for carotid bruits, enlarged kidneys, masses, and dilation of the aorta; (8) examination of the extremities for diminished pulses, bruits, and edema; and (9) neurologic assessment.

[43]Suggested initial laboratory screening includes determination of hemoglobin and hematocrit, complete urinalysis, measurement of serum potassium, calcium, and creatinine, electrocardiography, measurement of serum lipids and of uric acid concentrations.

[44]With additional noted detail: The objective of treating patients with hypertension is to reduce the morbidity and mortality associated with hypertension by achieving a goal blood pressure below 140/90mm Hg, if possible, with the use of both nonpharmacologic and pharmacologic therapies. Patients with hypertension inadequately controlled by anti-hypertensive therapy should be evaluated for possible causes of refractory hypertension; an interval history should be obtained which assesses factors that would include patient noncompliance, possible drug interactions, inadequate doses or inappropriate combinations of antihypertensive agents, excessive alcohol use, sodium retention, obesity, continued or progressive renal disease, as well as malignant or accelerated hypertension.

Although expectant management with follow-up within 1 to 2 months might be appropriate for patients with mildly elevated blood pressure (DBP of 90-105) determined on initial evaluation or on a follow-up visit after the institution of therapy, patients with diastolic blood pressures exceeding 105 to 110 mm Hg require prompt evaluation and adjustment of therapy. Patients with very severe hypertension (defined when the diastolic blood pressure measures at 120 or greater) require immediate evaluation or referral to a source of care. Patients found to have diastolic blood pressures exceeding 120 to 130mm Hg require immediate evaluation for the possibility of a hypertensive crisis. The presence of such a crisis (which includes both hypertensive emergency and urgency) is determined not by the absolute level of blood pressure elevation but rather by evidence of new or progressive end-organ damage. Evidence of such target damage should be immediately sought by the performance of a careful

Respondent departed in the extreme from this standard in his care, treatment, and case management of R.S., and he provided inadequate care for her both initially and during follow-up visits: he initially and repeatedly thereafter failed to take an appropriate history and perform an appropriate physical, and he failed to provide appropriate management for the severely elevated blood pressures in a patient being managed for chronic hypertension. Particularly markedly elevated blood pressures were recorded at multiple visits (e.g. 184/120 on March 11, 1991; 180/94 on May 28, 1991; 140/110 on August 19, 1991; 174/114 on October 23, 1991; 170/114 on February 17, 1992; 198/124 on March 20, 1992; 170/122 on March 24, 1992; 168/122 to 220/138 on March 25, 1992; 158/114 on March 4, 1993) but were not adequately addressed. Further, a treatment plan to address the hypertension was never not recorded in the chart and it is unclear precisely what medications R.S. was taking and at what doses. (See also, ¶ 9.A.b, post.)

ii. *Respondent Failed To Provide Appropriate Medical Care For R.S.'s Psychiatric Disorder.* The standard of care also posits that patients with psychiatric disorders, particularly those for whom psychotropic medications are prescribed or refilled, should not only have a medical evaluation on the chart but also a pertinent psychiatric history and mental status assessment. Careful, serial evaluation of suicidal risk (with a focus on intent and lethality) is a critical objective of

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history and physical examination, paying special attention to the optic fundi, the central nervous system, heart, lungs, abdomen, and peripheral arterial pulsations, coupled with laboratory examinations (urinalysis, CBC, chemical analysis of the blood) as well as, in some cases, a chest x-ray and CT scan of the head.

all physicians providing care to patients with major depression. If antidepressant medication is prescribed, regularly scheduled follow-up visits are required to adjust or modify the drug treatment prescribed (typically tricyclic antidepressants) on the basis of clinical response and development of side effects, to provide psychologic management, to longitudinally monitor the efficacy of the agent(s) prescribed, as well as to serially assess the need for continued therapy and the risk of suicide.

Respondent departed in the extreme from the requirements set by this standard in his care, treatment, and case management of R.S. Firstly, there is no psychiatric history or mental status evaluation documented in R.S.'s record, even when Respondent prescribed antidepressant medications (e.g., the Imipramine, Tofranil, Thorazine) for her. And any meaningful treatment plan was never developed (cf. ¶ 9.A.b, post), and any meaningful follow-up was utterly lacking.

iii. *Respondent Failed To Provide Appropriate Medical Care To Address A Number Of R.S.'s Acute Complaints.* The standard of care also posits that patients presenting with medical complaints should have, at a minimum, a pertinent history and physical examination performed, as well as an assessment and treatment plan clearly stated in the medical record. Respondent repeatedly departed from this standard: There is no complete medical history or physical examination documented in the medical record and there are no attempts to obtain outside or prior medical records. Such evaluations are vital in patients being managed longitudinally for medical problems such as hypertension,

foot infections with possible osteomyelitis, and a history of seizures.

Thereafter Respondent repeatedly failed to adequately address (or record an adequate interval history, clinical examination, and management plan) a number of acute complaints, which she presented. Without limitation, inadequate medical evaluation and management was provided vis-à-vis:

-her headache, vomiting, thirst, fatigue, and an inability to focus her eyes and thoughts on May 2, 1991;

-her recent seizure on May 6, 1991;

-her left knee pain, palpitations and fatigue on July 19, 1991;

-her weakness, vomiting, dizziness, and cramping in the extremities and back, on September 24, 1991;

-her foot and toe pain and an infected toe on multiple visits in 1991 and 1992;

-her severe head pain on March 24-25, 1992;

-her fatigue and postural symptoms with near syncope on April 30, 1993;

-her fevers and groin and foot pain on February 26 and June 30, 1993; and

-her general fevers and tremors on multiple visits in 1991-1993.

In addition,

b. *Throughout, Respondent Consistently Failed To Record In The Medical Record Full Treatment Plans, Or The Dosages Of Medications Being Prescribed.* The standard of the community

calls for a physician's records to be somewhat legible, both for future reference by the physician and/or his or her colleagues. A treatment plan (as well as a prior history and physical) must be taken and clearly documented in the record, and medications that are prescribed must be clearly noted, indicating the name of the medication, and its dosage and frequency. Respondent's records for R.S. depart from this standard: he consistently failed to record plans of treatment, and he failed to indicate the dosages of medications he was prescribing.

c. *Respondent Consistently Prescribed Medications For R.S. Without Having Performed A Good Faith Physical Examination.* Medications prescribed, adjusted, or refilled without an adequate evaluation or stated indication include, without limitation: Phenobarbital on May 6, 1991; Imipramine on June 6, 1991; premarin on June 6, 1991; and Thorazine on November 8, 1991.

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B. Unprofessional Conduct For Prescribing Without An Examination, Excessive Prescribing, and Violation of Drug Statutes. Respondent is also subject to disciplinary action for unprofessional conduct, now pursuant to sections 2242(a) and 2238 of the MPA and section 725 of the Code and because the matters set forth hereinabove also show that in the course of his care, treatment, and case management of R.S., (i) Respondent repeatedly prescribed dangerous drugs for her without having performed a good faith physical examination and documenting a valid medical indication [§ 2242(a)], (ii) Respondent repeatedly clearly excessively prescribed drugs for her [§ 725], and (iii) in so

doing, Respondent violated several state statutes regulating dangerous drugs and controlled substances [§ 2238] –to wit, sections 11153, 11154, and 11210 of California's Health and Safety Code, which require respectively that prescriptions for controlled substances be issued for legitimate medical purposes only, that they not be issued except in a physician's treatment of a pathology or condition, and that the substances be prescribed only in such quantity and for such period of time as is reasonably necessary. (Cf., fn. 5, ante.)

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10. Patient J.Z. Mr. J.Z., a 47 year old male, saw Respondent from June, 8, 1989, through January 18, 1993. Prior to 1992 the visits were for an assortment of medical complaints which Respondent managed longitudinally; in 1992 he was managed additionally for a major psychiatric illness. Thus:

1989

--Mr.Z. first saw Respondent on June 8, 1989 complaining of stomach soreness, a metallic taste in the mouth, excessive eructation [belching], dizziness and postural vertigo. Only a limited medical history was taken (consisting of notations that the onset of symptoms occurred 3 weeks after a visit to Mexico, the presence of heartburn, and the absence of melena, nausea, vomiting, and anorexia) and the physical examination was limited to a single comment, "tender" presumably describing the abdomen. A presumptive diagnosis was not recorded. Laboratory tests were ordered and Tagamet was prescribed.

--A follow-up was made on June 12th. The interval

history consisted solely of a comment that the stomach symptoms initially worsened but then improved; the recorded examination was limited to the notation that the abdomen was still tender. Respondent made a working diagnosis of gastroenteritis vs. gallbladder disease, and plans were made for a possible sonogram if symptoms persisted.

1990

--On January 5, 1990, J.Z. was seen for symptoms consistent with an upper respiratory infection, but no examination or treatment plan was recorded. On January 25th, a prescription for Deconamine-SR[45] and Septra-DS was phoned to a pharmacy, but the reasons are unstated. The next three entries in the medical record indicates that Rogaine hair solution was prescribed, but a pertinent history, examination, and treatment plan was not recorded.

--J.Z. was next seen on July 9th for a sore throat and rhinorrhea (4 days). Respondent's examination was limited to the notation "throat benign", and he prescribed Keftab 500mg[46] and Deconamine-SR. On October 31st laboratory tests were ordered, and Respondent subsequently prescribed Nicobid 500mg[47] for a triglyceride level of 536 and a cholesterol of 248.

--On November 13th, J.Z. presented with an upper respiratory infection and right elbow pain for two months. He was also seen for a cholesterol determination. Respondent's

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[45] Deconamine-SR (chlorpheniramine maleate) is a decongestant.

[46] Keftab (cephalexin hydrochloride) is an antibiotic.

[47] Nicobid is niacin, nicotinic acid, a B-vitamin.

examination was limited to the notation "not tender"; a diagnosis of "chest pain" and "tendonitis" was made, and a chest x-ray was ordered. An intramuscular injection of Rocephin 250mg was given.[48] J.Z. was prescribed Feldene, Augmentin 250mg, and a band for his tendonitis.[49]

1991

In February Respondent prescribed Voltaren and Darvocet N-100[50] for J.Z. In February also saw J.Z. when he had cut his hand with a saw. A dermatofibroma and seborrheic keratosis were excised and cauterized in August, and phenergan with codeine was prescribed for unstated reasons on October 3rd. On October 24th J.Z. was seen for an upper respiratory infection and testicular pain: no examination was performed; Trinalin was prescribed.[51]

1992

--On February 25th, J.Z. was seen for nightmares, "overwhelmed" thinking, and occasional suicidal thoughts. Other than these notations no other history was taken (e.g., the duration of symptoms, the suicidal risk, a past psychiatric history) and a mental status examination was not performed. Respondent prescribed Prozac (at an unspecified dose), Xanax .25mg, and Buspar.[52] On February 26th he was referred to and seen by L.C., Ph.D., a clinical psychologist at the North Orange

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[48] Rocephin (ceftriaxone sodium) is an antibiotic.

[49] Feldene (piroxicam) is an anti-inflammatory; Augmentin (amoxicilin) is an antibiotic.

[50] Darvocet is a Schedule IV narcotic analgesic.

[51] Trinalin (azatadine maleate) is an antihistamine-decongestant.

[52] Prozac (fluoxitine hydrochloride) is an anti-depressant; Xanax (alprazolam) is Schedule IV used to treat anxiety disorders; Buspar (buspirone hydrochloride) is also an anti-anxiety medication.

County Psychosocial Services. A crisis intervention approach was utilized to manage the "serious depression", "suicidal ideation", and impending separation from his wife. Counseling was provided, and a favorable response to the Prozac noted.

--On February 27th, J.Z. made two telephone calls to Respondent complaining of chest heaviness and panic attack. Respondent advised him to double his Xanax dose to .5mg BID. He was seen in follow-up on March 2nd. No history was taken, and J.Z. was given refill of the Xanax.

--On March 10th, he presented with "headaches" for the past 3 days, as well as light chest pain and tingling in the upper body and arms. No other evaluation was recorded and an EKG was not performed. J.Z. was told to discontinue the Prozac and to begin Tofranil 25mg (dose unstated).[53/]

--On March 16th, Respondent telephonically prescribed Elavil (10mg. qhs) for complaints of insomnia and pounding headaches. He saw J.Z. the next day after J.Z.'s wife -? (one B.) had called to report that J.Z. was thinking of suicide. Respondent made a diagnosis of depression and advised J.Z. to see a psychiatrist.[54/] He made a "contract to call" with J.Z. if he developed suicidal ideation, and also prescribed Elavil[55/] and Xanax at unstated doses.

--J.Z. next saw Respondent on March 23rd. No interval history or examination was recorded. He was advised to continue

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[53] Tofranil (imipraminehydrochloride), like Prozac, is an anti-depressant.

[54] J.Z. subsequently completed five counselling sessions for depression and anxiety with one J.B., M.A., the clinical director of the Wilson Family Living Counseling Center.

[55] Elavil (amitriptyline)is an anti-depressant.

with psychological counseling and with the Xanax (.5mg TID) and Tofranil (3 tabs at night). On April 13th J.Z. indicated he was feeling better. No mental status examination was performed. The Tofranil was increased to a dose of 150mg qhs, and he was continued on the Xanax. On May 5th J.Z. indicated he had cut back the Xanax to one a day and had discontinued the Tofranil. He was advised to continue with psychological counseling. Respondent prescribed Xanax on a prn basis.

--Respondent next saw J.Z. on July 1st, when he complained of anxiety and depression for 1½ weeks, as well as headaches and dyspnea (i.e., labored or difficult breathing) in the morning. No pertinent medical or psychological history was obtained and no examination was performed. Respondent diagnosed "depression" and told J.Z. to restart the Tofranil (@ 25mg and to increase it as tolerated to 150mg qhs). He also prescribed Buspar at an unstated dose.

--On July 27th, the Xanax was refilled (.5mg #50).

--In October J.Z. saw respondent for diarrhea and bloating for five days as well as abdominal pain and weakness. Epigastric pain was noted as well as "black pepto". Respondent's examination was limited to a comment of "diffuse tenderness" and a recorded blood pressure @ 120/80. A stool hemocult was not performed. Respondent diagnosed "gastroenteritis" and prescribed Maxaquin.

--On December 28th, J.Z. was seen for a sinus drainage and a hacking cough of 4 days duration. Respondent prescribed

Keflex 500 QID[56] and sudafed. On December 28th, Respondent prescribed Tussionex; on December 30th he prescribed Phenergan with codeine.

1993

--The final entry is dated January 18th, recording a complaint of a constant recurring cough for two weeks and a request for a medical refill. No history was obtained and no examination or treatment plan recorded.

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A. Gross Negligence, Repeated Negligent Acts, & Incompetence. Respondent is subject to disciplinary action pursuant to section 2234 because in the course of his care, treatment, and case management of J.Z. he demonstrated unprofessional conduct within the meanings of subdivisions (b)-[gross negligence] and/or (c)-[repeated negligence], and (d)-[incompetence], of that section. Particularly and without limitation, the following indicates that in the course of that care, treatment, and case management, (i) he was guilty of gross negligence by departing in the extreme from the standards of the medical community, or was guilty of repeatedly committing negligent acts by repeatedly departing from the medical community's standards, and (ii) that he demonstrated incompetence by displaying a lack of knowledge of medical matters and/or an inability to discharge his professional obligations:

a. *Throughout The Time He Saw J.Z., Respondent Failed To Record A Complete History and Physical Examination Or Provide*

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[56] Keflex (cephalexin) is an antibiotic.

Appropriate Follow-up Care For A Patient Managed Longitudinally For Both A Major Psychiatric Illness (With Psychotropic Medications) As Well As An Assortment Of Medical Complaints[57]. The standard of care posits that patients who are provided medical care for longitudinal medical needs, including psychiatric problems (such as depression and anxiety), should have a comprehensive medical history and physical examination performed and recorded. For patients being managed for major depression (or any other significant psychiatric disorder) the standard demands that a psychiatric history and examination (including a mental status examination) should also be performed. Careful, serial evaluation of suicidal risk is a critical objective of all physicians caring for depressed patients. Respondent utterly failed to heed the standard and departed in the extreme from it.

There is no complete medical history or physical examination in J.Z.'s chart, as is required for patients provided longitudinal medical care as well as a patient for whom psychotropic medications are being prescribed. Then, written treatment plans with recorded measurable objectives is lacking in the medical record. Follow-up progress notes, such as exist, are cursory in nature and illegible, and Respondent failed to adequately assess the efficacy of the medications he was prescribing.. With more particularity:

i. *Throughout The Time He Addressed J.Z.'s*

[57] J.Z. presented with a variety of acute medical complaints –e.g., testicular pain and URI on October 24, 1991, chest pain on March 10, 1992, shortness of breath and headaches on July 1, 1992, and diarrhea and abdominal pain in October 1992. At no point was any pertinent history and examination performed, or an assessment and treatment plan clearly devised and stated in the medical record.

Psychiatric Problems, Respondent Failed To Obtain And Record A Psychiatric History Or Provide Justification Or Adequate Follow-up For A Patient Started On Antidepressant Therapy and Anxiolytic Therapy (With Psychotropic Medications).

The psychiatric history and evaluation is inadequate for the psychiatric disorders being addressed. Particularly there, depressed patients who express thoughts of suicide demand immediate and careful evaluation of suicidal risk, with a focus on intent and lethality. Respondent utterly failed to adequately evaluate the suicidal risk potential posed by J.Z. when he expressed suicidal thoughts on February 25th and March 17, 1992, such as by a pertinent psychiatric history and mental status examination. Thereafter his treatment plan is incomplete and failed to insure the necessary follow-up. Indeed,

ii. *Throughout The Time He Saw J.Z., Respondent Consistently Failed To Record Full Treatment Plans And The Doses Of Medications He Was Prescribing.* A written treatment plan, with recorded measurable objectives is utterly lacking in the medical record, and follow-up progress notes, such as there are, are cursory in nature. Psychotropic medications are simply prescribed and/or refilled without a documented indication and without the performance of an adequate interval history and examination. Particularly, the follow-up after the prescription of the antidepressants was nonexistent for the purpose of determining the adequacy of therapy, adjusting dosage, ascertaining the need for continued therapy, monitoring side effects, and for longitudinally detecting and assessing suicidal

risk. In addition, periodic reassessments of the continued need for benzodiazepine therapy was inadequately documented in the medical record.[58]

iii. *During The Time He Treated J.Z., Respondent Repeatedly Failed To Adequately Address A Number Of Acute Complaints He Presented.* The standard of care posits that patients presenting with medical complaints should have, at a minimum, a pertinent history and physical examination performed, as well as an assessment and treatment plan clearly stated in the medical record. Respondent departed from this standard: During the time he treated J.Z. inadequate medical evaluation and management was provided for a number of acute complaints he presented. Without limitation, these included his failing to adequately evaluate or address J.Z.'s complaints of chest pain (March 10, 1992), shortness of breath (July 1, 1992), and abdominal pain (October 1992). He also failed to address the suicidal thoughts (February 25 and March 17, 1992).

b. *Throughout The Time He Saw J.Z., Respondent Prescribed Medications Without Having Performed A Good Faith Physical Examination.*

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[58]Xanax is a triazolo analog of the 1,4 benzodiazepine class of central nervous system active compounds). It is noted that the Physician's Desk Reference cautions that a "physician should periodically reassess the usefulness of the drug for the individual patient." (PDR (45th ed. 1991) at 2261.) As with any medication, it must be prescribed only after a diagnosis has been made, and then only where medically necessary and other treatment options have been fully explored.

The standard of care also posits that prior to prescribing any medication for a patient, that a physician take a careful medically significant history which includes a history of past treatment. A physician must be ever cognizant of the amounts being prescribed and how much has been taken in a given period of time. He or she must also make periodic assessments of the efficacy of the medication, noting any improvement in the underlying disorder for which it is being used. Such review and evaluation is imperative before an authorization is given for a prescription to be refilled. Lastly, a physician must be aware of the fact that continued use of certain drugs carries the risk of habituation and/or abuse, and that tolerance develops over time so that increasing doses of the substance will be required to produce the same effect, and may perpetuate an addiction, act in a synergistic manner with an addiction, or create an addiction in an unstable patient. During the period of time J.Z. was under his care, Respondent totally ignored these standards and departed in extreme from them.

B. Unprofessional Conduct For Prescribing Without An Examination, Excessive Prescribing, and Violation of Drug Statutes. Respondent is also subject to disciplinary action for unprofessional conduct, now pursuant to section 725 of the Code and sections 2242(a) and 2238 of the MPA because the matters set forth hereinabove also show that in the course of his care, treatment, and case management of J.Z., (i) Respondent repeatedly clearly excessively prescribed drugs for him; (ii) Respondent prescribed dangerous drugs without having performed a good faith physical examination and documenting a valid medical indication; and (iii) in so doing Respondent violated several state statutes regulating dangerous drugs and controlled substances —to wit, sections 11153, 11154, and 11210 of California's Health and Safety Code, which require respectively that prescriptions for controlled substances be issued for legitimate medical purposes only, that they not be issued except in a physician's treatment of a pathology or condition, and that the substances only be prescribed in such quantity and for such period of time as is reasonably necessary. (Cf., fn. 5, ante.)

Those matters show that throughout Respondent prescribed medications for J.Z. without having made a good faith prior medical examination, and that in addition in 1992 Respondent prescribed medication on a continuous basis wherein the amount prescribed and the length of time for which it was prescribed was inordinate.[59/]

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[59] In particular the PDR states: "XANAX ... [is] indicated for the management of anxiety disorders or for the short term relief of the symptoms of anxiety. [¶] [¶]The effectiveness of XANAX for long-term use, that is, more than four months, has not been established by systematic clinical trials. The physician should periodically reassess the usefulness of the drug for the individual patient." (PDR (45th ed. 1991) at 2261.)

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11. Patient J.M. During 1992 and 1993, Respondent rendered professional medical services to Ms. J.M., a 30-year old employee in his office (his medical assistant and radiology technician), who had a recent history of major depression with obsessive-compulsive behavior and anxiety, and a past history of panic attacks and bulimia:

--On September 3, 1992 Respondent gave J.M. an intramuscular injection of 1.25cc of Estradiol.[60/] No medical history or physical examination was taken or recorded, and the injection was administered without a stated indication. Blood tests were ordered. A list of medications was also recorded: Prozac 20mg 5xday, Bumex 2mg/day[61/], potassium 2/day, and levothyroid .2mg/day[62/].

--On September 17, 1992, Respondent gave her a flu vaccination and on October 2nd, another injection of Estradiol.

--On October 19th, J.M. was seen for complaints of sinus tenderness, fatigue, sweats, chills, and fever. No examination was performed. It was noted that Rocephin had been administered 2 weeks prior and that when the symptoms returned 2 days before, another injection of Rocephin 250mg was given IM.[63/]

--On November 6, 1992, Respondent reduced the dosage of

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[60] Estradiol (Estrace) is used in Estrogen replacement therapy.

[61] Bumex (bumetanide) is a diuretic used for treatment of edema.

[62] Levothyroid (cf. Synthroid) is used to treat hypothyroidism.

[63] Rocephin (ceftriaxone sodium) is an antibiotic.

Estradiol because of continued bruising and night sweats. No other history was obtained and no physical examination was performed.

--On December 3, 1992, J.M. complained of night sweats for 2 weeks and an increase in the bruising on her legs. Respondent did not perform a physical examination. He administered Estradiol IM.

--On January 4, 1993, Respondent again administered a 1.5cc injection of Estradiol IM. [It was noted that during week 3 she experienced more sweats and that they improved after taking provera.) On February 1, 1993 a 1.25cc injection of Estradiol was given (IM).

[--On February 11, 1993, J.M. was seen in consultation by a pulmonologist, Dr. S.M. A medical history was taken, and was notable for a chronic history of daytime sleepiness, a history of Hashimoto's thyroiditis in 1978, a history of premature ovarian failure, a history of depression in the spring of 1992, as well as well as a past history of a tonsillectomy. Her medications were noted to include Synthroid, Provera, Estradiol, and Prozac. Dr. M's assessment was "possible narcolepsy with restless legs syndrome vs depression" and she recommended that a diagnostic polysonogram and multiple sleep latency tests be performed after J.M. was weaned off Prozac and Vivarin[64]. On February 24th, J.M. was seen by another physician (Dr.R.) who also felt a need for the patient to be tapered off her medications in order to the sleep studies to be performed.

[64] Vivarin is an over-the-counter caffeine waker-upper.

J.M. said she had reduced her Prozac to 60mg/day; she was told to reduce it to 20mg/week until she was off it. Dr.R. started J.M. on Dexedrine.[65/]]

--On March 2, 1993, Respondent administered 1.5cc of Estrogen (as well as dexedrine 5mg BID. No interval history or examination was recorded, and the indication for the medication was not documented. Estrogen injections were administered on April 5, May 4, and June 3, 1993, without history, physical or documented indication.

--On June 11, 1993, Respondent provided J.M. with Dexedrine tablets, but made no entry of such in the medical record.

[--On June 14th, J.M. was seen by a Dr.C. and it was noted that she had experienced an episode of depression in the interim, and had restarted herself on the Prozac. She was advised to continue the Dexedrine and the Prozac at a dose of 20mg/am.

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A. Gross Negligence, Repeated Negligent Acts, & Incompetence. Respondent is subject to disciplinary action pursuant to section 2234 because in the course of his care, treatment, and case management of J.M. he demonstrated unprofessional conduct within the meanings of subdivisions (b)-[gross negligence] and/or (c)-[repeated negligence], and (d)-[incompetence], of that section. Particularly and without limitation, the following indicates that in the course of that

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[65] Dexedrine (dextroamphetamine sulfate) is a Schedule II amphetamine "upper" used in hyperactivity, narcolepsy, obesity.

care, treatment, and case management, (i) he was guilty of gross negligence by departing in the extreme from the standards of the medical community, or was guilty of repeatedly committing negligent acts by repeatedly departing from the medical community's standards, and (ii) that he demonstrated incompetence by displaying a lack of knowledge of medical matters and/or an inability to discharge his professional obligations:

a. *During The Time He Treated J.M., Respondent Failed To Record A Complete Medical History And Physical Examination And Provide Adequate Follow-up For A Patient Prescribed And Administered Estrogen Replacement Therapy*. The standard of care posits that patients who are provided medical care for longitudinal medical needs should have a comprehensive medical history and physical examination performed and recorded. But there is no complete history or physical examination in Respondent's chart for J.M. and there is no records of any attempts to obtain prior or outside medical records. A history should have been taken in standard medical fashion, which would include prior surgeries and hospitalizations, past and current medical conditions, medications, allergies, habits, family history, social history, and a review of systems. A complete physical examination should also have been performed and documented in the medical record including blood pressure, a funduscopic examination, a neck and thyroid examination, a cardiopulmonary examination, a breast examination, an abdominal examination, a pelvic examination, an extremity examination and a neurologic examination.

Particularly, in a patient provided Estrogen therapy for premature ovarian failure, such an evaluation should include a medical history with specific inquiry regarding its contraindications and precautions, blood pressure determination, as well as breast and pelvic examinations. Absolute and relative contraindications to the use of Estrogen must be evaluated.[66/] Then, after the institution of Estrogen replacement therapy, follow-up visits are required to identify and evaluate any abnormal bleeding patters, to assess the adequacy of the therapy, and to monitor the patient for the development of adverse reactions. In addition, patients maintained on hormone replacement therapy should be evaluated annually to test blood pressure, to have breast and pelvic examinations, and mammography when indicated. Respondent ignored these community standards.

b. *During The Time He Treated J.M., Respondent Failed To Record (Or Obtain Outside Records Providing) An Adequate Psychiatric History And Examination Or Ensure/Provide Adequate Follow-up For A Patient Provided Antidepressant Medication (Prozac) And A Central Nervous System Stimulant (Dexedrine).* The standard of care posits that patients who are prescribed psychotropic medications, such as antidepressant therapy, require not only a medical history and examination but also a pertinent psychiatric history and examination including mental status. Regularly scheduled follow-up visits (which would include an interval history as well as psychiatric assessment, are required

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[66]Absolute contraindications to estrogen use include undiagnosed uterine bleeding, recent myocardial infarction and stroke, acute liver disease, a history of estrogen-dependent cancer, and recurrent, acute, or spontaneous thromboembolic disease. Relative contraindications include established ischemic hear disease, gall bladder disease, pancreatitis, migraine headaches, and epilepsy.

to assess the need for dosage adjustment or additional therapy, to assess the need for continued therapy, to monitor the patient for the development of any adverse reactions, to provide adjunctive psychological management, and to permit serial evaluation of suicidal risk.

There is absolutely no psychiatric history or mental status evaluation documented in J.M.'s record despite his prescribing/providing psychotropic medications to her that included Prozac and Dexedrine. In addition the indications for them as well as a full treatment plan are totally absent from the medical record. Moreover, inadequate clinical follow-up was provided for the conditions for which the medications were prescribed.

c. *During The Time He Treated J.M., Respondent Prescribed Or Administered Medications Without A Good Faith Medical Examination.*

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B. Unprofessional Conduct For Prescribing Without An Examination, Excessive Prescribing, and Violation of Drug Statutes. Respondent is also subject to disciplinary action for unprofessional conduct, now pursuant to sections 2242(a) and 2238 of the MPA and section 725 of the Code and because the matters set forth hereinabove also show that in the course of his care, treatment, and case management of J.M., (i) Respondent repeatedly prescribed dangerous drugs for her without having performed a good faith physical examination and documenting a valid medical indication [§ 2242(a)], (ii) Respondent repeatedly clearly

excessively prescribed drugs for her [§ 725], and (iii) in so doing, Respondent violated several state statutes regulating dangerous drugs and controlled substances [§ 2238] –to wit, sections 11153, 11154, and 11210 of California's Health and Safety Code, which require respectively that prescriptions for controlled substances be issued for legitimate medical purposes only, that they not be issued except in a physician's treatment of a pathology or condition, and that the substances be prescribed only in such quantity and for such period of time as is reasonably necessary. (Cf., fn. 5, ante.)

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12. Patient M.S. Respondent rendered professional medical services to Ms. M.S., another 30-year old employee in his office, from 1990 through October, 1992.[67] Mrs.S. had a troubled past: an abusive alcoholic father and a marriage to an abusive alcoholic husband. She also had a past history of a suicide attempt in 1980 with an overdose of Percodan.

--On July 23, 1990, Respondent administered Rocephin 500mg intramuscularly. A pertinent medical history or examination was not recorded, nor was the indication for the injection documented in the medical record.

--On April 8, 1991, respondent prescribed and dispensed 30 Prozac 20mg, 100 Xanax .25mg, and retin-A. A pertinent medical history or examination was not recorded, nor was the indications for the medications documented in the medical record.

[67] In 1989 Respondent had prescribed amoxicillin to M.S.'s daughter (-?, one J.) and on December 20th, had dispensed amoxicillin suspension to her nieces (-?). A medical history and physical examination was not recorded, nor was a treatment plan.

--On April 28, 1991, M.S. complained of insomnia, fatigue, and weight loss of unstated duration, as well as mention of occasional suicidal ideation. Respondent made a diagnosis of "depression/anxiety" and prescribed Xanax .25mg TID, and referred her for psychiatric/psychological consultation.

--On June 20, 1991, Respondent prescribed 30 Prozac 20mg and 100 Xanax.

--On September 20, 1991, M.S., was referred to and subsequently seen by a clinical psychologist who felt that she was a classic battered wife with major depression. He recommended supportive psychological counseling.

--On October 19, 1991, Respondent again prescribed 100 Xanax.

--On January 29, 1992, Respondent prescribed 30 Pamelor 25mg[68/]; the clinical indication for the medication was not recorded, nor was a history, examination, or treatment plan. On March 10th, M.S., was taken to the Emergency Room at Saddleback Hospital following a drug overdose (25 of the Pamelor tablets) after an argument with her husband. Following the suicide attempt, Respondent referred her to College Health Resource Center where she received seven counseling sessions between March 12 and May 13, 1992.

--On May 4, 1992, a pregnancy test was positive, and M.S. was referred to an obstetrician. Visits on June 3 and October 2, 1992 involved a referral for a D&C for an inevitable abortion.

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[68] Pamelor (nortriptyline) is a tricyclic anti-depressant.

--On June 1, 1992, M.S. was seen for "cramps". A medical history was not taken, nor was any indication of a physical examination recorded.

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A. Gross Negligence, Repeated Negligent Acts, & Incompetence. Respondent is subject to disciplinary action pursuant to section 2234 because in the course of his care, treatment, and case management of M.S. he demonstrated unprofessional conduct within the meanings of subdivisions (b)-[gross negligence] and/or (c)-[repeated negligence], and (d)-[incompetence], of that section. Particularly and without limitation, the following indicates that in the course of that care, treatment, and case management, (i) he was guilty of gross negligence by departing in the extreme from the standards of the medical community, or was guilty of repeatedly committing negligent acts by repeatedly departing from the medical community's standards, and (ii) that he demonstrated incompetence by displaying a lack of knowledge of medical matters and/or an inability to discharge his professional obligations:

a. *During The Time He Treated M.S., Respondent Failed To Record A Complete Medical History And Physical Examination, Or To Provide Appropriate Follow-up Care For A Patient Managed Longitudinally For A Major Psychiatric Illness.*

Once again, the standard of care posits that patients who are provided medical care for longitudinal medical needs, including psychiatric problems (such as depression and anxiety) must have a comprehensive medical history and physical

examination performed and recorded. For patients being managed for major depression (or any other significant psychiatric disorder), a psychiatric history and examination (including a mental status examination) must also be performed. Careful, serial evaluation of suicidal risk (with a focus on intent and lethality) is a critical objective for all physicians treating and managing depressed patients.

Respondent departed in extreme from this standard during his care, treatment, and case management of M.S.:

i. First, a meaningful complete medical history and physical examination is utter lacking for M.S.

ii. Second, during the time he treated M.S., Respondent failed to take and record an appropriate psychiatric history and examination; the psychiatric history and evaluation, such as exists, was inadequate for the psychiatric disorder for which she was treated.

iii. Third, Respondent never devised a written treatment plan with recorded measurable objectives for M.S. and essentially failed to provide adequate follow-up care after he started her on antidepressant therapy and anxiolytic therapy. Indeed, the follow-up provided after the prescription of the antidepressant medication was practically non-existent for the purposes of determining the adequacy of therapy, adjusting dosage, ascertaining the need for continued therapy, monitoring side effects, and for longitudinally monitoring suicide risk. Instead, psychotropic medications were simply prescribed and refilled without a clearly-stated indication and without an

interval history and examination.

b. *During The Time He Treated M.S., Respondent Consistently Failed To Record Full Treatment Plans, Or The Dosages Of Medications Prescribed.* Once again, Respondent never developed a written treatment plan with recorded measurable objectives for M.S. The standard of the community also calls for a physician's records to include, both for future reference by the physician and/or his or her colleagues, a clearly documented treatment plan; it also calls for it to include documentation of all medications that are prescribed, indicating the name of the medication, and its dosage and frequency. Respondent's records for M.S. depart from this standard: he consistently failed to record plans of treatment, and he failed to indicate the dosages of medications he was prescribing.

c. *Respondent Consistently Prescribed Medications For M.S. Without Having Ever Performed A Good Faith Physical Examination.* Medications were prescribed, adjusted, or refilled without an adequate evaluation or stated indication.

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B. Unprofessional Conduct For Prescribing Without An Examination, Excessive Prescribing, and Violation of Drug Statutes. Respondent is also subject to disciplinary action for unprofessional conduct, now pursuant to sections 2242(a) and 2238 of the MPA and section 725 of the Code and because the matters set forth hereinabove also show that in the course of his care, treatment, and case management of M.S., (i) Respondent repeatedly prescribed dangerous drugs for her without having performed a

good faith physical examination and documenting a valid medical indication [§ 2242(a)], (ii) Respondent repeatedly clearly excessively prescribed drugs for her [§ 725], and (iii) in so doing, Respondent violated several state statutes regulating dangerous drugs and controlled substances [§ 2238] —to wit, sections 11153, 11154, and 11210 of California's Health and Safety Code, which require respectively that prescriptions for controlled substances be issued for legitimate medical purposes only, that they not be issued except in a physician's treatment of a pathology or condition, and that the substances be prescribed only in such quantity and for such period of time as is reasonably necessary. (Cf., fn. 5, ante.)

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Costs

13. Section 125.3 of the Business and Professions Code provides that in any Order issued in resolution of a disciplinary proceeding, a Board may request the Administrative Law Judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case (incurred up to the date of the hearing), including charges imposed by the Attorney General.

14. As charged herein Respondent's actions involve multiple violations of the Medical Practice Act. Accordingly, the Board will seek reimbursement from Respondent of the costs involved in investigating and enforcing this Matter: if it prevails on the Accusation the Board will request the

Administrative Law Judge hearing the case to order Respondent to reimburse it for its reasonable investigative, expert witness and prosecutorial costs. The amount of these costs will be provided at the Hearing.

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WHEREFORE, Your Complainant requests that the Board hold a hearing on the matters alleged herein, and following said hearing, issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A32571 heretofore issued to respondent Jefferson C. Hendrix, M.D.; and/or

2. Taking such other and further action as the Board deems meet in the premises; and

3. Ordering Respondent to reimburse the Board with its costs of investigating and enforcing this Matter in such amount as is proffered at the hearing.

DATED: July 18, 1994

DIXON ARNETT
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant